STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155579	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	7440 N 825 E HOPE, IN47246

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00085803. Complaint IN00085803 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: February 21, 22, 23, and 24, 2011 Facility number: 000286 Provider number: 155579 AIM number: 100291000 Survey team: Diana Sidell RN, TC Penny Marlatt RN Sharon Whiteman RN Census bed type: SNF/NF: 68 Total: 68 Census payor type: Medicare: 12 Medicaid: 46	F0000	We respectfully request paper compliance for this Plan of Correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Other: 10 Total: 68 Sample: 15 Supplemental sample: 2 This deficiency also reflects state findings in accordance with 410 IAC 16.2. Quality review completed 3/1/11 by Jennie Bartelt, RN.			

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F0332 SS=D	Based on observation, record review, and interview, the facility failed to ensure an error rate of less than 5% during medication pass observation. This finding is related to 4 medication errors made during a total of 43 medications observed being administered. This resulted in an error rate of 9.3%. The deficient practice affected 2 of 14 residents observed receiving medications during the medication pass. (Resident #46, Resident #23) Findings include: 1. On 02/22/11 at 4:10 p.m., RN #1 was observed to administer medications to Resident #46. Resident #46 received 40 milligrams of Furosemide (diuretic medication), 20 milligrams of Lisinopril (blood pressure medication) and (2) 325 milligrams of Tylenol (medication used to relieve pain/fever). Review of Resident #46's clinical	F0332	**We respectfully request paper compliance for this Plan of Correction. This facility will ensure that it is free from a medication error rate greater than 5%. Resident #46 was affected by this deficient practice. The attending physician was promptly notified. Resident was monitored for 24 hours with no change in vital signs or condition noted. Family was also promptly notified. Medication orders have been clarified and are being administered as directed. Resident #23 ws affected by this deficient practice. The attending physician and family were notified promptly of the medication error. Resident was monitored for 24 hours. No adverse event or change in vital signs or condition was noted. RN#1 will be disciplined progressively or terminated for further violations. Date of completion 3/26/11. All residents could be affected by this deficient practice. Every nurse will be educated on medication administration basics and audited for performance.. See Attachment A and B. This medication administration in service and audit will be completed by 3/26/11. All newly hired nurses are trained as part of their**	03/26/2011

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	record on 02/22/11 at 4:40 p.m. indicated the following: An admission physician's order, dated 02/14/11, indicated Resident #46 was to receive Lisinopril 10 milligrams every day at 6:00 a.m. and Tylenol 500 milligrams every 6 hours as needed. The physician's order did not include an order for Tylenol 650 milligrams, nor was there an order for Furosemide. Interview of Unit Manager #2 on 02/22/11 at 4:45 p.m., indicated the pharmacy had probably sent the wrong "roll of meds (medications) and today was the first day they had been given." Unit Manager #2 indicated Resident #46 did not have an order for Furosemide and the incorrect dosage of Lisinopril was given. Review of a "Medication Record" for February 2011 indicated Lisinopril 10 milligrams was to be given to Resident #47 daily at 6:00		**orientation process. This process will be monitored by doing annual and as needed nursing skills review of Medication Pass Observation. Any errors or improper procedure will have immediate re-education.The DON or designee will do the Medication Pass Audits for 10% of residents bi-weekly for 4 weeks, monthly for 2 months, and quarterly thereafter. See Attachment c.The Medication Audit results will be reviewed by the Quality Assurance Committee and any recommendations by the Committee will be followed.**	

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	a.m. and Tylenol 500 milligrams was to be given to Resident #46 every 6 hours as needed. The "Medication Record" lacked documentation supporting the resident was to receive Furosemide. 2. On 02/22/11 at 4:20 p.m., RN #1 was observed to administer 1 and ½ capsules of Tylenol 325 milligrams to Resident #23. Review of Resident #23's clinical record on 02/22/11 at 4:45 p.m., indicated the following: Resident #23 had a physician's order for February 2011 which included an order, dated 07/14/10, for Tylenol 500 milligrams as needed - give 1 ½ capsules (750) milligrams at bedtime as needed for pain. The physician's order did not include an order for Tylenol for the dose that was observed being given. A medication administration record (MAR) for February 2011 indicated			

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	Resident #23 was to receive Tylenol 500 milligrams - give 1 ½ capsules (750) milligrams at bedtime as needed for pain. The MAR did not include an order for Tylenol 325 milligrams. 3.1-25(b)(9) 3.1-(c)(1)			